



TEXAS DEPARTMENT OF HEALTH

Medicaid Case Management PROVIDER APPLICATION

SECTION 1

Application for: **9** THSteps Medical Case Management **9** Targeted Case Management for High Risk Pregnant Women and Infants

Provider Name:

Address:

City:

County:

Zip:

Phone Number:

Fax Number:

E-Mail Address:

TDH Region:

Case Management Director Name & Title:

Contact Person to be on List for Referrals/Publication:

List all counties in which applicant proposes to provide TDH Medicaid case management Services:

Type of Entity:

Individual _____

Agency _____

Agency Director/Owner

-

Funding Type Entity:

Public _____

Private (Nonprofit) _____

Private (For Profit) _____

*FQHC

(Public Entities are those that are owned or operated by state, county, city, or other local government agency or instrumentality. All other entities are considered to be private providers.)

*(Federally Qualified Health Centers)

Describe all current services provided. If applicant is an agency, include detailed information about agency history and structure, whether it is affiliated with another agency or corporate service, services provided and clients served. List any existing contracts with the State of Texas, including the Texas Department of Health (TDH). If applicant is an individual case manager, please describe any other social service or Medicaid providers with which you are affiliated.

SECTION 2

If your TDH Medicaid case management client needs assistance with any of the following issues, where would applicant refer them in the communities (counties) to be served? Please include the agency name, address, telephone number, and a contact person. Each county needs to be addressed individually. Indicate in the appropriate column if applicant currently provides this service or makes referrals and for what length of time.

For Example:

If the client needs emergency shelter

Name: Safe Place
Address: 100 Main Street
Timbuktu, Texas
Phone: 512-333-4444
Contact: Mary Poppins

County of _____

**Advocating for Special
Needs at School
or
Education-Related
Services**

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_____ Referred
_____ Provided
_____ New Provider

_____ Length of Time



| | | |
|---|-------------------------------------|--|
| Durable Medical Equipment/Supplies, i.e., Wheelchair, Diapers, Feeding Tubes | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time |
| Medically Dependent Children Program (MDCP) | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time |
| Community-Based Alternatives (CBA) | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time |
| In-Home & Family Support (IHFS) | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time |
| Community Living Assistance & Support Services (CLASS) | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time |

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|--|---|---|
| <p>Home & Community Services (HCS)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Texas Health Partnership/ Children's Health Insurance Program (CHIP)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Children With Special Health Care Needs (CSHCN)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Family Planning</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Prenatal Health Care Services</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |

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|--|-------------------------------------|---|
| <p>Utility Assistance</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Emergency Food Assistance</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Mental Health</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Substance Abuse</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Emergency Shelter</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |

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|---|-------------------------------------|---|
| <p>Transportation Services (Community Resources & Medicaid Transportation)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Locating a Doctor/ Dentist on Medicaid (THSteps O&I)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Nutritional Services (WIC)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Occupational, Physical & Speech Therapy Rehabilitative Services</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Respite Care/ Attendant Care</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |

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|---|---|---|
| <p>Acute/Hospital Care</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Early Childhood Intervention (ECI)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Local Health Department</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Mental Health and Mental Retardation (MHMR)</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |
| <p>Blind & Visually Impaired Resources</p> | <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | <p> <input type="checkbox"/> Referred <input type="checkbox"/> Provided <input type="checkbox"/> New Provider <input type="checkbox"/> Length of Time </p> |



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|---|--|---|
| Resources for Migrant Workers & their Families | | <input type="checkbox"/> Referred |
| | | <input type="checkbox"/> Provided |
| | | <input type="checkbox"/> New Provider |
| | | <input type="checkbox"/> Length of Time |
| | | |
| Child Support Assistance | | <input type="checkbox"/> Referred |
| | | <input type="checkbox"/> Provided |
| | | <input type="checkbox"/> New Provider |
| | | <input type="checkbox"/> Length of Time |
| | | |
| Information & Referral Network | | <input type="checkbox"/> Referred |
| | | <input type="checkbox"/> Provided |
| | | <input type="checkbox"/> New Provider |
| | | <input type="checkbox"/> Length of Time |
| | | |
| Child Care | | <input type="checkbox"/> Referred |
| | | <input type="checkbox"/> Provided |
| | | <input type="checkbox"/> New Provider |
| | | <input type="checkbox"/> Length of Time |
| | | |
| Housing | | <input type="checkbox"/> Referred |
| | | <input type="checkbox"/> Provided |
| | | <input type="checkbox"/> New Provider |
| | | <input type="checkbox"/> Length of Time |
| | | |

SECTION 3

Identify any limitations to the population applicant proposes to serve. For example, if applicant does not serve clients over twelve (12) years of age or provide services to pregnant women only, please note. Limitations must apply to all populations served and not be specific to the Medicaid population.

SECTION 4

***Please read the TDH Medicaid case management rules for service to which you are making application carefully before completing this section. Please number responses to each statement below. (Add additional pages as necessary.)**

- (1) Describe your plan for a comprehensive case management program including all service components. If making application for both THSteps MCM and TCM/PWI, must provide separate response for each service.
- (2) How will applicant ensure that clients/families are aware of their freedom to choose among all existing case management providers? If applicant provides multiple Medicaid services, how will applicant ensure freedom of choice when referring clients for Medicaid services?
- (3) Describe how clients may be referred to TDH Medicaid case management services.
- (4) For THSteps MCM, describe how applicant will address the home visit program requirement. For TCM/PWI, will home visits included in services?
- (5) Will applicant be using community service aides/promotoras and if so how?
- (6) What position(s) will supervise the case managers and community service aides/promotoras? Please include an organizational chart.
- (7) Describe applicants plan for client continuity of care; including designated case manager, Medicaid termination of services, case closure, eligibility issues, transfer of services, etc.
- (8) Describe how applicant will act as an advocate on behalf of TDH Medicaid case management clients and empower clients to access services independently.
- (9) If applicant is a provider of other services reimbursed by Medicaid and/or the State of Texas through contract, fee for service or in a capitated rate, i.e., discharge planning from an institution, care coordination by a STAR (Medicaid Managed Care) provider, therapist, etc., please list and describe how applicant will distinguish those services from Medicaid case management services. In addition, how will applicant ensure nonduplicative billing/reimbursement?
- (10) How will applicant ensure that services are culturally sensitive and are in compliance with ADA and LEP requirements?

SECTION 5

- (1) Describe how applicant participates in coalitions, collaborations, networking meetings, and CRCGs. List the specific meetings in your community.
- (2) Describe plans for community education and outreach activities which promote TDH Medicaid case management in your community.
- (3) Identify the resource directories applicant will utilize in the various communities (counties) served. Describe how the directories be will be current and made available to case management staff.
- (4) If proposed area to serve has Medicaid Managed Care, please identify the plans in those communities and describe how applicant will coordinate services and referrals with that organization.

SECTION 6

The applicant must develop and implement an internal quality assurance plan with appropriate internal policies and procedures. If applicant is provider of other services to clients, quality assurance activities for TDH Medicaid case management must be integrated into the applicant-s overall Quality Assurance Program/Evaluation Plan. The plan must be attached to the application and include the following components:

- (1)
 - c Documented quarterly record review.
 - c Documented annual direct observation of staff/client interactions.
 - c Documented feedback to case managers on results of QA activities.
- (2) Staff positions who will participate in evaluation activities. Include the professional qualifications of this staff.
- (3) How the findings from client, case manager (THSteps MCM), and PCP (THSteps MCM) satisfaction surveys will be documented and communicated with case management staff and utilized in planning and/or improving existing program services and systems.
- (4) State how the findings from the record reviews and observation evaluation will be used in planning and/or improving existing program services and systems.

SECTION 7

Document the number of current case management staff who meet the definition of **Acase manager** in the program rules and who are eligible to bill Medicaid for reimbursement. Record in **Afull-time equivalents** (FTEs) the amount of time they will devote to TDH Medicaid case management activities. (For example, two staff each working 20 hours a week dedicated to TDH Medicaid case management would equal one FTE)

THSteps MCM

TCM/PWI

Registered Nurses

Social Workers

Registered Nurses

Social Workers

Total #

FTE

Total #

FTE

Total #

FTE

Total #

FTE

Please attach résumés and copies of license for RN-s and/or copies of license renewal notices or original license issue letters for Social Workers. Résumé must include proof of experience, degree held & year obtained.

Document the other personnel who will be performing activities related to TDH Medicaid case management. Record in FTEs, the amount of time they will devote to case management. Do not include the RN/SW case managers here.

Community Service Aides

Other (Describe)

Total #

FTE

Total #

FTE

Anticipated monthly unduplicated number of new admissions – the number of new client intakes an applicant can complete for TDH Medicaid case management services in any given month.

New Pregnant Women

New Infants 0-1

New Children 1-21

Anticipated monthly total caseload for case management services – the total number of active clients for which an applicant can provide TDH Medicaid case management services at any given point in time.

Total Pregnant Women

Total Infants 0-1

Total Children 1-21

SECTION 8

Provider Assurances:

If approved as a TDH Medicaid case management provider, the applicant certifies that they will:

1. Provide case management services in a manner consistent with the Targeted Case Management for High Risk Pregnant Women and High Risk Infants/ THSteps Medical Case Management Rules, Policies and Procedures and Medicaid rules.
2. Participate in cost analysis studies of case management as requested by TDH.
3. Comply with all TDH reporting requirements.
4. Submit to periodic monitoring and evaluation reviews by TDH as described in program policy.
5. Share individual patient information including appropriate releases of information, with other pertinent health, social and case management providers so that indicated referral and tracking may occur.
6. Assure TDH that advocacy will be a primary role in service provided and no conflict of interest exist. Assure that clients are given freedom of choice of all case management providers and in all referral/provider decisions.
7. Be in good standing or employ registered nurses and licensed social workers, as Medicaid case managers, who meet all of the case manager requirements as detailed in the TDH Medicaid case management rules. The applicant further certifies that each case manager will attend a TDH-approved case management orientation/education program prior to billing for services.

Case Management Program Director

Date

Agency Director/Owner

Date



SECTION 9

Regional Director of Social Work or
Designee

Date

☐ Approve ☐ Disapprove

Regional Office Comments:

Central Office review staff:

☐ Approve ☐ Disapprove

Date

Division Director

Date

Comments: